MISSOURI COMMISSION ON PATIENT SAFETY
MEETING MINUTES
February 18, 2004
10:00 a.m. – 4:00 p.m.
Hampshire Room, Ramada Inn
Jefferson City, Missouri

OFFICIAL

Commissioners in attendance: Gregg Laiben, Thomas Cartmell, Deborah Jantsch, Susan Kendig, Nancy Kimmel, Kevin Kinkade, Scott Lakin, Alan Morris, Kathryn Nelson, Bea Roam, William Schoenhard, Stephen Smith, Barry Spoon, James Utley, Kenneth Vuylsteke, Lori Scheidt, and Tina Steinman.

I. CALL TO ORDER

Dr. Gregg Laiben, Chairperson
The meeting was called to order at 10:15 AM. Silent roll call was taken.

Review of Draft Minutes from the previous meeting:

Written comments received in advance from Nancy Kimmel were noted. Ms. Kimmel also noted that Leapfrog had not been spelled correctly in some cases. Dr. Morris moved to approve as amended. Mr. Schoenhard seconded. The minutes were approved on a voice vote as amended with no objections.

Housekeeping items:

Linda Bohrer called the Commissioners' attention to the announcement of Patient Safety Week, March 7 through 13.

Other handouts for today correspond to the scheduled presentations. Internet links to information on the PreP 4 Patient Safety program have been posted on the Insurance Department's Patient Safety Commission web site.

The meeting on March 3rd is the last meeting during which speakers are scheduled to present information. That meeting will be very full, but no more speakers are scheduled after that.

The Insurance Department is having Dr. Hickson's presentation from the February 4th meeting transcribed. Commissioners indicated they would like to have the transcription emailed to them.

II. PRESENTATION ON MISSOURI'S PEER REVIEW LAW

Ken Vuylsteke, Commissioner, and Rex Burlison, Chief Counsel in the St. Louis office of the Missouri Attorney General, provided case law and led discussion of Missouri's current peer review law, section 537.035, RSMo, available on line at http://www.moga.state.mo.us/statutes/C500-599/5370000035.HTM.

Mr. Vuylsteke began with the following points:

- After participating in the Patient Safety Commission, it's clear that Missouri's peer review law should be included in any recommendations.
- Revising the current law would be preferable to tort reform, but there is tension between patient safety and patients' rights to pursue medical malpractice litigation.
- Work like Kathryn Nelson's at the University of Missouri-Columbia Hospital and Vanderbilt's project at St. John's are risky under the current law. Missouri's law extends immunity and confidentiality only to specified categories of medical professionals and institutions, and hospital CEOs. Confidentiality of root cause analysis and other innovative, progressive methods depend on the involvement of non-medical professionals.
- Commissioners will recall from Dr. Hickson's presentation that actual medical errors are a small portion of medical malpractice litigation. If the peer review law were extended to appropriate non-medical people involved with patient safety improvement, it may not detract from the rate of medical malpractice litigation, because people litigate poor medical outcomes more frequently than they litigate actual medical errors.
- Trial attorneys may be persuaded to support revision of the peer review law more easily than they can be persuaded to support caps on damages.
- Extending the protections of the peer review law to patient safety activities could be seen as impinging on a patient's right to sue. If the law protected patient safety activities the way it protects peer review activities, it will be harder for trial attorneys to gather the information necessary to prove medical malpractice occurred.
- "Subsequent remedial measures" taken as a result of peer review activities cannot be used by a patient to prove medical malpractice occurred. If this were allowed, it could discourage institutions from correcting problems. The purpose of the peer review law is to protect the free flow of information in order to correct problems and prevent further harm.
- The peer review law does not prevent trial attorneys from gathering information that can be used to argue medical malpractice occurred. While peer review committee records cannot be discovered, individuals with pertinent information can be deposed. They cannot refuse to answer questions about an incident, even if the incident was also the subject of peer review.

Mr. Burlison continued:

- Under certain circumstances, the protections provided by the peer review law can be waived. The courts have applied the metaphor of a sword and shield. The peer

review law shields information and discussion so that corrective action can occur. However, if the corrective action takes the form of restriction or denial of a medical professional's privileges, the peer review committee is like a weapon. In these situations, the peer review committee is deemed to have waived the protections in the law. The medical professional in such situations has a right to evaluate and question the information that lead to professional restrictions.

- In addition, if a pleading is entered in a case where a professional takes an institution to court over a corrective action that becomes part of the public record. There could be a request to close the records, but someone has to remember to do that. A patient's attorney could review any public records in a medical malpractice case.
- A current legislative proposal (Commissioners believed it to be HB 1304) would eliminate the "sword" part of the peer review law, making peer review protections absolute. This is not desirable from the medical professional's point of view, because they lose the right to compel sharing of information that was used against them.
- Case law indicates that the existing peer review law cannot be used to shelter activities unrelated to peer review. A managed behavioral health company tried to use the peer review law to prevent plaintiff's attorneys from gaining access to utilization review records. The courts would not agree to this application of the peer review law protections. Therefore, it's reasonable to be concerned that the courts would not agree to apply peer review protection to patient safety activities, unless the law was changed.

Q: Is the law for medical doctors only? What if the hospital CEO is involved in the peer review committee?
A: Several categories of medical professional are named. Institutional executives that participate in peer review activities are also immune from civil liability. However, the statute isn't clear that such executives also have confidentiality protection.
Q: Does the committee have to be established or standing, or is it allowed to be ad hoc?
A: The law doesn't require a standing committee, but whatever committee is formed must be officially appointed for purposes of peer review.
Q: Are risk managers protected?
A: If they are not also clinicians, they are not protected, and they are not among the types of people that may comprise a protected peer review committee.

- Some possible problems with Missouri's current law are impacting the patient safety system at UMC. The UMC system goes beyond facts. It includes the opinions of those reporting and goes to non-clinicians. This system may or may not be protected by the peer review law. But there is no explicit, clear protection for this kind of system. A gap in communication results, where patient safety managers can't be involved with peer review. St. John's work on the Vanderbilt program is another example of unprotected activity.
- Kansas created confidentiality protection for risk managers. **This might be a model for Commissioners to look at.**

- Trial attorneys find a potential drawback to laws like the one Kansas adopted. As mentioned earlier, attorneys can get to the same information considered by a peer review committee. Attorneys do this through deposing key personnel. A non-clinical risk manager might use the organization's economic power over employees and medical staff to prevent attorneys from getting access to the right people. Protected patient safety activities could thus be used to accomplish a purpose not related to patient safety.

Kathryn Nelson commented that risk management carries the implication of litigation. Patient safety carries no such connotation. Kansas's method of protecting risk management may not be good enough for patient safety activities that extend to the entire system, such as lighting or equipment issues. Patient safety is not looking at whether or not any specific individual gave good care.

Thomas Cartmell concurred that even with the protection extended to risk managers, the peer review law was never intended to protect patients. It was intended to protect the medical staff disciplinary process.

The Commissioners discussed the issue of exclusive contracting and the ability to terminate contracts "at-will". Some argued that this wasn't really a patient safety issue. Others said it was, if you look at how the peer review law ought to be changed to provide further protection for reporting patient safety issues. **It was agreed that if the Commission serious desired to recommend altering Missouri's peer review law, additional presenters from various points of view would be crucial.** The Insurance Department staff can work on bringing in the right presenters.

Q: In the peer review law, does the definition of a health care professional include pharmacists or therapists?
A: No. The statute explicitly names several different types of professionals, and only those types are included.
Thomas Cartmell offered an opposing viewpoint, arguing that other statutes applied. Mr. Burlison supported Ken's original answer, and pointed back to the legislative history of the peer review law. Since the legislature has added specific types of professionals piecemeal, one can't extrapolate that to apply to all licensed health care professionals.
Q: Confidentiality is protected for things like the minutes, discussion and findings of a peer review committee, but action taken against a medical professional based on those findings causes confidentiality to be lost. Is this correct, and if so, would corrective action aimed at a systems problem cause a similar loss of confidentiality?
A: That's correct, and no, if there were no litigation based on action taken against a specific professional, there would be no loss of confidentiality.
Q: If confidentiality protection is waived in one proceeding, and there is a separate proceeding related to medical malpractice, is confidentiality protected in the separate proceeding?
A: Maybe not, if records from the first proceeding aren't sealed. If confidentiality protection is waived, someone has to take action to regain the protection. There has to be a request to seal the records.

Q: Can you legally separate investigation and correction of system problems from investigation and action against a bad acting doc?
A: That's what Kansas has done. Actually, Kansas's law isn't specifically for risk managers, but for general risk management related activities. Missouri has no similar legal protection.

Dr. Utley felt the Commission should work to develop such protection in Missouri.

Dr. Spoon commented based on his work at the Board of Healing Arts. Attorneys are always interested in what the Boards have to say, and there's no protection for the Boards. The Commission should keep this in mind if recommendations to change the peer review law are made.

The Commission broke for lunch at 11:20 and reconvened at 12:20

III. PRESENTATION ON P.R.E.P. 4 PATIENT SAFETY

David Swankin, President of the Citizen's Advocacy Center presented information on the Practitioner Remediation and Enhancement Partnership, a pilot project of the Health Resources and Services Administration.

Mr. Swankin provided copies of his slide presentation and copies of specific remediation cases. He made the following additional points:

- Researchers and patient safety advocates talk a lot about how poor incident reporting rates are, even though institutions and professionals are required in some cases to make reports. PreP4 studied why the reporting rates were so low. It turns out, hospitals are reluctant to make reports to licensing boards if the only thing licensing boards can do is take action against a practitioner's license. That doesn't really help the hospital. Even though they may have a contractual right, hospitals may be reluctant to dismiss professionals, if as an outcome they would be required to report that to the applicable licensing board. This could have an impact on low rates of reporting.
- The current regulatory environment may not serve the public need adequately, and something more pro-active is needed.
- Performance problems are system problems. Systems don't adequately detect bad actors or marginal performance.
- Sometimes root cause analysis doesn't get into performance deficits.
- JCAHO classification of sentinel events shows that competency assessments are significant factors in certain types of events.
- The PreP 4 program has tracked patient safety groups, commissions and boards in most states where they have been developed. Missouri is unique in having the directors of 3 different professional licensing boards involved.
- The PreP 4 process provides a way to use state licensing boards to compel remedial training and education for practitioners that have demonstrated performance problems, but who have not yet merited standard disciplinary action.

- It's very important to make a distinction between the remediation advocated by PreP 4 and the role of licensing boards in disciplining licensees. There is already public suspicion that boards collude with practitioners. PreP 4 isn't a way for boards to evade their disciplinary obligations. It's a vehicle for correcting harmful actors before discipline is warranted. For example, the case with Dr. Robert Courtney in Kansas City would not have been appropriate for PreP 4 intervention.
- A practitioner can come into a PreP 4 program through either a hospital referral or a Board referral. Hospital referrals are viewed as the most likely path.
- Boards may be able to dismiss complaints that don't warrant disciplinary action. Some states give their Boards a range of disciplinary actions, while other states don't. No state gives their Boards positive, non-disciplinary intervention authority.
- PreP 4 accomplishes a long list of good things. It serves to institutionalize the flow of information between hospitals and Boards. It works in addition to mandated reporting; it doesn't replace mandated reporting. It fosters trust between hospitals and Boards. It clarifies the difference between remediation and disciplinary cases. In the long run, it should reduce the number of cases that have to be reported.
- PreP 4 is not mandatory and isn't national. States individually choose whether or not to be involved. Missouri was one of the first states to get involved through their Board of Healing Arts.
- PreP 4 is another way to identify systems flaws. Review of the cases handled so far indicates this is true, particularly in cases where nursing professionals are in a remediation program.
- Dichotomy in the patient safety discussion is a bad thing. People tend to believe that there is either a system fix or a people fix, but not both. As noted earlier, performance problems and systems problems overlap.
- The PreP 4 program leads to a change in the culture of the medical community by providing a role for the Boards to play that is not disciplinary in nature.
- North Carolina has a process of looking back at their remediation cases several months after remediation is complete.
- The program leaders in Washington DC don't get any more than summary information about each case. This is an example of the level of privacy in the program.
- Litigation can impose an intervention. This method may not be fruitful. The PreP 4 program puts people together to develop the best agreed upon remediation.
- Involvement of state licensing Boards is important because these are usually the only organizations that can monitor a person as that person moves around.
- Program experience indicates that few hospitals are ready to change the way they perceive and use their state licensing Boards. Hospitals shouldn't be forced into using PreP 4 by mandates. For example, California has a $10 thousand dollar fine for hospitals that fail to report as required to the licensing Boards. Hospitals in California fear that referrals to PreP 4 might expose them to a fine if the Board feels the referral should have been a report.

Mr. Swankin's recommendations for the Commission were:

- **Recommend that all Missouri hospitals develop PreP 4 Patient Safety programs in partnership with the Missouri Board of Registration for the Healing Arts.**
- **Recommend that the Missouri Board of Nursing participate in the PreP 4 Patient Safety Programs.** Nursing boards are especially important for detecting systems problems in long term care.
- **Recommend that the Missouri Hospital Association encourage member hospitals to participate in PreP 4 Patient Safety programs in collaboration with the boards of medicine and nursing.**

Q: What's PreP 4's experience with aligning with medical associations?
A: Not sure. Each state is different, but PreP 4 encourages participating Boards to work closely with professional and hospital associations. A good working relationship with the associations is hoped to avert misunderstanding and reactionary resistance. States are also encouraged to get an important hospital leader to participate first. Reactions are mixed.
Q: Has PreP 4 been presented to Missouri hospitals or the association?
A: (Tina Steinman responded.) Not yet. Informational meetings are planned, but the medical association was approached first.
Dr. Spoon commented that attempts were made earlier to get MHA involved. The problem is resistance from the doctors to anything that comes from the Boards. Boards have resorted to heavy-handedness in the past. That has left a legacy of distrust and legislative issues that restrict the Boards. For the Vanderbilt project at St. John's in Springfield, the hospital used economic pressure to require staff docs to participate in the intervention process.
Mr. Swankin pointed out how this supports the theory that the primary drivers for PreP 4 are bound to be the hospitals.
Dr. Jantsch commented that the population PreP 4 is trying to reach is really the medical staff, not the hospitals. In Missouri, successful physician wellness programs have come from the Medical Association, not the Boards. There is definitely support for this kind of remedial intervention. **The Commission should reach out with programs like PreP 4 to medical staff groups, who are unlikely to be aware of PreP 4 as an option.** Medical staff doctors need these kinds of programs. However, there is an economic barrier to consider. Time away from the hospital for remediation decreases productivity.
Dr. Utley noted that one way to assure that PreP 4 is not perceived as punitive is to present specifically as the alternative to further disciplinary action. **He agreed with Dr. Jantsch about the importance of approaching the medical associations.**
Mr. Schoenhard suggested that each Commissioner use the time between today and the next meeting to make contact with associates in the professional and institutional associations.
Dr. Laiben suggested that PreP 4 could be rolled out in one receptive community at a time.
Q: If one nurse needed remediation, wouldn't several? How often does this come up as an issue?
A: All the cases in the PreP 4 program to date have been there 5 months or less, so it's a little too early to tell. But since each remediation is crafted on a case-by-case basis, it

would be surprising to see several practitioners required to undergo the same remediation.
Q: What happens from the time a person presents PreP 4 with a case and asks the program to get involved? What's the process?
A: PreP 4 as a program doesn't get involved. The licensing Board handles design and remediation with the institution and the licensee. The process is an initial contact with the Board, assessment, design of remediation and completion of remediation. System issues may come up as a by-product of the 3 parties coming together to discuss the appropriate remediation.

The Commission thanked Mr. Swankin and took a 15-minute break.

IV. DISCUSSION PERIOD

Kathryn Nelson distributed copies of the results of the issue ranking that Commissioners were asked to do at the last meeting.
The Commission discussed at length what form their future meetings should take and what work product they want to end up with. **The one thing everyone clearly agreed on was that some kind of permanent body or entity should be established that would play a leading role in ongoing efforts to improve patient safety throughout Missouri.**

It appeared that Commissioners wanted to focus on 5 main categories:
Patient Safety Center of some kind
Reporting events/near-misses, and protection for making those kinds of reports
Promoting the use of root cause analysis and Failure Modes Effects Analysis
Education of providers, statewide culture change and improving interdisciplinary communication
Patient empowerment

It was tentatively agreed that certain lead Commissioners would be assigned to work in smaller groups to compile information on each topic, based on presentation to the Commission and any other outside research needed. (For example, before he had to leave, Mr. Swankin mentioned he had a spreadsheet of all the states' peer review laws, which would provide the best possible overview of models the Commission could consider for extending protection under Missouri's law.) Insurance Department staff would assist as much as they could, but staff from DHSS, Missouri PRO, MHA and organizations represented on the commission could also.
Kathryn Nelson and William Schoenhard agreed to use the Patient Safety Center topic as a preliminary test to see if the method described above would be satisfactory. They will work with agency and association staff to have a report on the various types of safety centers established in other states. A report will be available identifying key decision issues in developing or establishing a permanent commission/center. The final recommendation will be further discussed in conjunction with the report at the March 17 meeting.

It was generally agreed that Thomas Cartmell and Ken Vuylsteke would ultimately be involved with drafting of any recommendation dealing with peer review issues and protection of patient safety data.

The 5 groups listed above will be listed on the Commission's website, and Commissioners will be asked to volunteer for at least one topic, two at the most.

Dr. Spoon suggested that the Executive Directors of the various health licensing Boards be asked to comment on how each topic area would affect their agencies. Commissioners agreed this would be insightful information to include in any final report.

There were no public comments. The meeting adjourned at 4:10 PM.